COUNSELING SOLUTIONS, LLC 725 HEARTLAND TRAIL MADISON, WI 53517

Patient Registration Form

Last Name _____ First Name _____

Gender _____ Date of Birth _____

Address _____City _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work _____

SS# (Required for Insurance) _____-_____-_____

Custodial Parent/Guardian/Emergency Contact _____

Insurance Information

Primary Insurance Name of Insurer _____

Group _____ Policy# _____

Subscriber Name _____ D.O.B. _____

Relationship to Patient _____ Employer _____

Primary Insurance Name of Insurer _____

Group _____ Policy# _____

Assignment and Release

I, the undersigned certify that I, (or my dependent), have insurance coverage and assign directly to all insurance benefits, if any, otherwise payable to me for services rendered. I understand and agree that I am financially responsible for all charges, legal and clinical, whether or not paid by Insurance. I hereby authorize the provider and all employees to release any and all information necessary printed or verbal to secure the payment of benefits. I authorize the use of this signature on all claims, manual or electronic.

Signature _____ Date _____